EXHIBIT 4

Chevron

Expatriate Exam Recommendations GO-1769

Examiner: When completed, please forward to the Chevron regional medical manager office checked below:

- ☐ Americas: Chevron Health and Medical, P.O. Box 6024, San Ramon, CA , USA 94583
- ☐ Asia / Pacific Region: Chevron International Pte LTD, Health and Medical, Chevron House, 30 Raffles Place #21-01, Singapore 048622
- ☒ Europe / Eurasia / Middle East / Africa: Chevron Health and Medical 1 Westferry Circus, Canary Wharf, London, UK, E14 4HA
- ☐ Chevron Shipping Medical Manager, 6101 Bollinger Canyon Road, BR1, Room 4646, San Ramon, CA, USA 94583
- ☐ Other Chevron Medical Facility: _____

Part A –Examinee Information

For medical confidentiality, please complete one form per examinee. If the examinee is a dependent, please complete Part B below

Last Name	First Name	MI	CAI	Birth Date (mm/dd/yyyy)		Examinee ID
SNOOKAL	MARK		MVZM	04 - 13 – 1972	☒ Male ☐ Female	

Job Title	Operating Company	Current Work Location	Destination Location
IEA RELIABILITY TEAM LEAD		EL SEGUNDO, USA	ESCRAVOS, NIGERIA

Part B: Chevron Employee Information

If the examinee is a dependent, please complete this section with the Chevron employee information.

Last Name	First Name	CAI	Chevron Employee ID

Job Title	Operating Company	Current Work Location	Destination Location

Number of dependents in Host Location: _____

Part C – OpCo / Business Unit Contact – Human Resources, Sponsor (if applicable), other.

Name	Phone No.	Date (mm/dd/yyyy)

Contact Address	City	State/Province	Postal/Zip Code	Country

Part D – Examination - *The recommendation below is based on a review of the medical history and physical examination.*

Exam Type: INITIAL EXPAT EXAM (ROTATIONAL)

Date of Exam (mm/dd/yyyy): 07/24/2019 Exam Location: MEL DEL RAY

State/Province: CALIFORNIA Country: USA

Disposition

☒ ***Employee***

- ☐ FIT for Duty
- ☒ NOT FIT for Duty
  - Describe: REMOTE LOCATION. CAN BE CLEARED FOR ASSIGNMENT IN LAGOS
- ☐ FIT for Duty with Limitation(s) (list below and provide estimated duration of limitations)
  - Describe:
- ☐ Failed to comply with requested evaluations
  - Describe:
- Exam Periodicity: ☐ One Year ☐ Two Years ☐ Other

☐ ***Dependents***

- ☐ Cleared
- ☐ Not Cleared
  - Describe:
- ☐ Cleared with Limitation(s) (list below and provide estimated duration of limitations)
  - Describe:
- ☐ Failed to comply with requested evaluations
  - Describe:
- Exam Periodicity: ☐ One Year ☐ Two Years ☐ Other

Examiner Name (please print)	Signature	Date (mm/dd/yyyy)
DR. ASEKOMEH ESHIOFE		08/15/2019

Address	City	State/Province	Postal/Zip Code	Country
CHEVRON HOSPITAL	WARRI	DELTA		NIGERIA

GO- 1769 (9-13)